



**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
DIVISION OF HEALTH, WELLNESS AND DISEASE CONTROL  
MICHIGAN DENTAL PROGRAM**

**FY 11/12**

Are you having a dental emergency?  Yes  No

Last dental appointment:	Do you have a dental provider? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____
--------------------------	--

How long in pain:	Problem Area: Lower Left or Right.....Upper Left or Right <small>Circle One</small>
-------------------	--

**Demographics**

Name: \_\_\_\_\_  

Last
First
Middle Initial

SS#: _____	Mailing Address (All MDP related mail will be sent to this address) _____ _____ City: _____ State: _____ Zip Code: _____ County: _____ Phone Number: ( ) _____
Date of Birth: ____/____/_____	
Are you a Michigan Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Assistance Program # _____ (on ScriptGuideRX card)
--	---

Gender (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Native American	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African National <input type="checkbox"/> Arab/Chaldean
---	---	---

**Income/Other Coverage Eligibility**

Family Size: _____ (including self, spouse &/or dependants living with you)	My TOTAL gross (pre-tax) <b>monthly</b> income is: \$ _____ (please attach most recent months paystubs, bank statement, or notice of award for SSDA or SSI)
---	--

YES	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have Medicare?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have Private Health Insurance? (such as BC/BS, PHP, HAP)
<input type="checkbox"/>	<input type="checkbox"/>	Do you have Private Dental Insurance? (such as Delta Dental, BC/BS)

**HIV Status** \*(Labs must show a detectable viral load and/or Positive/Reactive Western Blot)

Absolute CD4 number/mm3: _____	Test Date: __/__/_____	Labs attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV RNA/ Viral Load: _____ copies	Test Date: __/__/_____	<b>Physician Signature:</b> _____

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I understand that if I become enrolled in a health insurance, or dental insurance program that pays for any portion of my dental or medications or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Drug Assistance Program (DAP) and Michigan Dental Program (MDP) in addition to my pharmacist, dentist and physician, and that I may no longer be eligible to receive assistance from the DAP/MDP.

I understand that if I am a Medicare recipient that I must enroll in a Medicare Rx plan or provide proof of creditable coverage to the DAP. I authorize the DAP/MDP to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program representative, or other individuals as required and necessary. In addition, specific agencies and phone numbers are listed below.

The information that I have provided on this application is complete and true to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the instructions and have followed the necessary steps that are required for me to be on the Drug Assistance Program/ Michigan Dental Program.

I understand that I must reapply annually, prior to March 31 every year to receive assistance with my medications from the DAP/MDP.

I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that my assistance will be inactive until all the requirements are met.

I understand that if any of the information provided on this application changes that I must notify the DAP/MDP immediately.

In addition, I understand that failure to report changes and/or reporting of inaccurate information may affect DAP/MDP coverage and program eligibility.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

**AGENCY OR PERSON**

**PHONE NUMBER**

**Case Manager** \_\_\_\_\_

**Dentist** \_\_\_\_\_

**Other (family members, friends, partners)** \_\_\_\_\_

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name of Applicant** \_\_\_\_\_

**print name**

**Please allow 14 working days for processing for non emergency cases**

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:

Michigan Dental Program  
109 Michigan Avenue, 9<sup>th</sup> Floor  
Lansing, Michigan 48913  
Phone: (888) 826-6565  
Fax (517) 335-7723

<b>MDP office use only</b>	
<b>Confirmed MDP Coverage:</b>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Michigan Resident <input type="checkbox"/> Income <input type="checkbox"/> Labs(Proof of Status)	Denied _____ Date __/__/____  Reason Code: _____  Initials _____
Date __/__/____ Initials _____ #____-____-____	